Department of Labor & Industries
Self-Insurance Section
PO Box 44891
Olympia WA 98504-4891

QUARTERLY STATEMENT OF SUPPLEMENTAL BENEFITS PAID
FOR SELF-INSURED EMPLOYERS

Name of Self-Insured Firm			UBI Number
Firm Representative (if applicable)			**FOR QUARTER**
Mailing Address			From: To:
City	State	ZIP + 4	Account ID

Self-Insured employers are entitled to reimbursement for all increased and retroactive payments of temporary total disability compensation made to injured workers entitled to such monies, in accordance with WAC 296-15-210 and RCW 51.32.073, except those cases where an employer continued an injured worker on wages. Reimbursement shall be made upon the completion and submission of this statement. For LEP claims, the worker must be paid at the higher of method A or B. If method B is used, no supplemental reimbursement is payable.

(1) "S", "T" & "W" Claim Number	(2) Name of Injured Worker	(3) Date of Injury	(4) T/L Comp. @ D.O.I.	(5) T/L Now W/Increase Added	(6) Amount of Increase	(7) Number of Days Paid	(8) Amount of Reimbursement Due Employer

Total (9)

DEPARTMENT USE ONLY Approved for Payment	
By	Date
Amount	
Warrant #	Date

I (We) the undersigned, hereby certify the above stated payments have been made to the claimants identified on this report and the figures are true and complete for the period covered.

Signature

Type or print your name

Title

Area Code and Phone Number